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# Postscript on Health Care Dispute Resolution: Conflict Management and the Role of Culture

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# POSTSCRIPT ON HEALTH CARE DISPUTE RESOLUTION: CONFLICT MANAGEMENT AND THE ROLE OF CULTURE

**Edward A. Dauer***

## INTRODUCTION

The articles in this Symposium volume mark a turning point in the application of dispute resolution strategies to the field of health care. Together, they describe how the conventional attributes of alternative dispute resolution ("ADR") may be enhanced—where they are not replaced—by the more capacious and context-sensitive characteristics of conflict management. That change, motivated in part by the failure of ADR to attain great sway and salience in the health care field and facilitated in part by a shift in the culture of health care itself, holds promise for both fields. If the ideas and applications chronicled here take hold, as they undoubtedly will, health care stands to benefit from the kinds of contributions that dispute resolution has made to other fields, and the theory and practice of dispute resolution will evolve in response to important lessons learned about adapting to new environments. This Article may serve only to highlight the contributions the authors of the articles in this volume have already made to both branches of that future.

## I. ADR AND CONFLICT MANAGEMENT

### *A. ADR*

There is no uniform definition of ADR, other than a general agreement that the acronym abbreviates the phrase "alternative dispute resolution." Some ADR practitioners might object that the relatively cabined definition offered here does not describe the limits

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of what they do. Others may say that this portrait of ADR is just the lawyers' dominant vision and not that of other dispute resolution practitioners who approach the subject from other platforms. They would all be correct. Some, working in health care as well as other areas, have long done what the articles comprising this volume announce as new. Many have been doing it in guises other than ADR—under monikers such as risk management, human relations, compliance system design, and even preventive law. Others, working in the name of ADR, have employed the very kinds of techniques described here under the contrasting label of conflict management. They have been in the minority, however, and all may be asked to forgive the posing of archetypes for the sake of illustrating, even if magnifying, the nature of the differences.

That being said, the practice of ADR is inhibited by three congenital characteristics, each of which may have limited its effectiveness in health care. For one thing, ADR bills itself as an alternative to litigation. For another, ADR limits itself to addressing disputes. And third, most ADR is accomplished through the intervention of a neutral third person.

### *1. Characterization of ADR as an Alternative to Litigation*

Neither of the first two characteristics—the focus on litigation and on disputes—has ever been necessary to achieving the goals of ADR and, to some degree, the focus on each has been a mistake. Their origins may lie in the sources of support that ADR drew upon during its formative period. Going back at least as far as Chief Justice Warren Burger's plea for relief from burgeoning dockets, courts have seen ADR as a way of reducing the cost, as well as the incidence, of the only thing they deal with: litigation.[1] Similarly, the business sector, an early and well-heeled supporter of the movement, climbed on the ADR bandwagon in response to unwelcome increases in their legal costs, likewise seen as the consequence of unnecessary and

1. C. J. Warren E. Burger, *Isn't There A Better Way?*, 68 A.B.A. J. 274 (1982).

excessively expensive litigation.[2] While corporate accounting methods include in legal costs the price of lawyers and courts and experts and judgments, seldom do corporate books account for the value of the unrealized advantages of, for example, a preventive approach.[3]

The alternative to litigation theme is, of course, mainly a lawyer's view of the world. The fact is, in real life, litigation is statistically trivial. If one envisions all of the conflict that occurs in a given place in any given day—all of the spats, frictions, disagreements, sharp words, annoyances, breakdowns, and other ways that people bump into and off of each other—it is not hard to envision how very little of that is ever recognized as a wrong deserving of redress. Even then, the recognition of a wrong leads to the potential for litigation only after emerging from several additional stages of filtering or transformation: The wrong must be recognized as the invasion or loss of a legally cognizable right, the recognition of the right must be converted into a motivation to act on it, the motivation must bring the actor to a lawyer, the decision must be made to consider litigation, the matter must be filed as a lawsuit, and any settlement efforts must fail.[4] We do not have good data about the first stage—the conversion of a conflict into a recognized wrong—which is very likely the stage with the largest drop-off percentage. There are, however, indicators of the rates of transformation for many of the others. To consider some examples, even in cases in which there has been significant, negligently-caused, and actionable injury, only about 25% of the

2. One of the earliest organizational efforts was that of the Center for Public Resources, now the CPR Institute for Dispute Resolution ("CPR"). The CPR is a coalition of businesses and business lawyers dedicated to the development and implementation of alternative dispute resolution ("ADR"). *What We Do*, The CPR Institute for Dispute Resolution, *at* http://www.cpradr.org./CPR_AboutUs.asp?M=1.1 (2004).

3. *See generally* Ronald J. Gilson, *Value Creation by Business Lawyers: Legal Skills and Asset Pricing*, 94 YALE L.J. 239 (1984) (discussing the difficulties in assigning a value to the contribution of attorneys in business settings).

4. For a description of a similar set of transformations, see William L.F. Felstiner, Richard L. Abel, & Austin Sarat, *The Emergence and Transformation of Disputes: Naming, Blaming and Claiming*, 15 LAW & SOC'Y REV. 630, 630-649 (1981). See also the discussion of "attribution theory" in Sally Lloyd-Bostock, *Propensity to Sue in England and the United States of America: The Role of Attribution Processes*, 18 J.L. & SOC'Y 428 (1991).

potential claimants assert a claim of right.[5] Of those, 13% see a lawyer. Of those who see a lawyer, 29% file a lawsuit.[6] Of all the lawsuits filed, only 5% ever go to trial.[7] Based on the product of these fractions, of all recognized and actionable personal injuries, the proportion that results in suit being filed is about 1%, and the proportion that actually goes to trial is about .05%. If that product is reduced by the initial drop-off from occurrence of conflict to recognition of legal wrong, then formal litigation is a statistically insignificant fraction of the whole experience of conflict.

To the extent that the "alternative" means alternative to litigation, ADR is by the same measure not a frequently-needed form of therapy. When limited in that way, ADR misses the opportunity to be an alternative to the ways in which the great bulk of troubling conflict is actually dealt with—by successful or unsuccessful negotiation, by avoidance, by breakdown, by anger sublimated and transported to another time and place, by the exercise of authority, or by concession. Some of those techniques are satisfactory, while others are not. In health care, those that are not satisfactory take their toll not only on the disputants, but on the quality of care they in turn provide to their patients.[8] ADR, when limited to serving as an alternative to litigation, misses the opportunity to provide an alternative to unsatisfactory means of dealing with conflict, and the much larger opportunity to contribute positively to future health care quality.

### *2. The Focus on Disputes in ADR*

The second characteristic of ADR is only slightly more subtle. By focusing on disputes, ADR presumes the existence of a dispute. That,

5. Richard E. Miller & Austin Sarat, *Grievances, Claims and Disputes: Assessing the Adversary Culture*, 15 LAW & SOC'Y REV. 525, 544-46 (1981). In medical malpractice situations, the rate is about half of that. *See* TROYEN BRENNAN ET AL., PATIENTS, DOCTORS AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 11-4 (1990).

6. In medical malpractice cases, the percentage is far smaller. *Id.*

7. The rate in federal courts may be even lower. One commentator reported a net trial rate of less than two percent in 2002. T.R. Franklin, *The Vanishing Trial*, Euclid Managers, *at* http://blog.euclidmanagers.com/home/the-vanishing-trial.html (Nov. 22, 2004) (citing a November 2004 report in the Journal of Empirical Legal Studies).

8. Debra Gerardi, *The Culture of Health Care: How Professional and Organizational Cultures Impact Conflict Management*, 21 GA. ST. U. L. REV. 857 (2005).

too, is an imaginary and unnecessary constraint. At the very least, it narrows the scope of the application of ADR to only some of the problems that an entity or an industry may have. If a scrub nurse and a surgeon shout at each other in the operating room, that is a conflict. If all of the labor deck nurses "rulebook" their dealings with some of the doctors, is that a dispute? It is surely a conflict and a problem, and patient safety hangs in the balance. But it is not, in the conventional sense, a dispute. A real, live, rip-roaring fight—a dispute—may be only a symptom of a deeper and broader set of conflicts, some of which may only sometimes emerge in a form recognizable as a dispute. ADR, so limited, is like a bandage on a diabetic patient's non-healing wound: It does not necessarily address the disease. It is true that any competent mediator, brought in to deal with an overt fight, will plumb its origins and at least try to broaden the parties' attention to include the underlying causes. The question, however, is whether a mediator will ever be brought in when there has been no outburst or even where there has been an outward indication of conflict that was later submerged again by concession, authority, or avoidance.

### *3. Reliance on Third Party Neutrals in ADR*

That ADR techniques would revolve largely around the practice of neutrals is hardly surprising. ADR is a natural replication of the lawyer's world, in which the objective neutral presence stands above the self-interested unreliability of the disputants. Furthermore, facilitative processes such as mediation rely on the confidential neutral as a solution to the dilemma of engaging in interest-based bargaining in a world occupied with undetectably adversarial opponents.[9] And, perhaps more than these other factors, ADR was developed largely by people with an interest in developing a field of employment within their area of expertise.

9. Interest-based negotiation requires disclosure of each party's interests to the other. That very disclosure, however, allows a non-collaborative negotiator to take advantage of the candid disclosure to the disclosing party's disadvantage. Simultaneous confidential disclosures to a mediator solve this dilemma by allowing interests to be revealed without the risk of exploitation.

The limitations created by this reliance on third parties are equally unsurprising. It adds cost. It imposes an outsider into a world that may not quite trust or welcome outsiders. It says to the disputants, at least implicitly and perhaps condescendingly, that resolving the problem is something they have not been able to do by themselves. It requires, at the very minimum, that the disputants recognize the existence of a problem, which they may not want to do. And, again perhaps more than these others, in most instances it takes time. While ombuds may be available on the spot and in real time, outside neutrals typically are not. The dispute arises, and sometime later the neutral arrives, like an emergency room doctor who works only by appointment. Again, and with some important exceptions, the limitations created by ADR's reliance on third parties may limit its usefulness in health care settings.

### *B. Conflict Management*

Living alongside ADR, in its shadow though antedating it, is a field of practice and inquiry that attends to the kinds of not-yet-dispute conflicts which ADR fails to address. Along with its ungainly name, preventive law has the advantage of being, like Moliere's bourgeois gentleman's prose, something lawyers have been doing all their professional lives without quite knowing it was something special.[10] Preventive law has an analytical and empirical history of trying to fashion a coherent theory out of such prosy observations as: "People will assert claims when they experience a 'feeling of injury.'"[11] The combination of these two fields—preventive law and ADR—is the core characteristic of conflict management.

Until recently, efforts to achieve an integrated theory of conflict management have been largely unsuccessful (because largely ignored) to the disadvantage of both preventive law and ADR. The

10. The National Center for Preventive Law at the California Western School of Law in San Diego, California "acts as a clearinghouse for information and as a network for those interested in the theory of Preventive Law." *Welcome to the NCPL*, National Center for Preventive Law, *at* http://www.preventivelawyer.org/main/default.asp (last visted Apr. 12, 2005).

11. LOUIS M. BROWN & EDWARD A. DAUER, PLANNING BY LAWYERS: MATERIALS ON A NONADVERSARIAL LEGAL PROCESS 309-10 (1978).

emergence of the new understanding of dispute resolution in health care, while not yet traveling under that name, portends exactly that combination.

## II. ADR IN HEALTH CARE

The scholars and practitioners whose articles are included in this volume are among the leaders in the effort to bring the techniques of dispute resolution to the world of health care. They and others are united by a quartet of shared axioms. First, they posit that the health care field is rife with conflict, as would be expected of an industry that has been through nothing less than revolutionary reorganization. Second, they believe that unresolved conflict presents a risk to the health care industry's own rekindled focus on patient safety. Third, they know that the ADR family of techniques has a demonstrated potential for effective conflict management. And fourth, they recognize that, with some notable exceptions, despite their efforts to sell ADR to the health care industry, for the most part, health care has not bought much of it.

### *A. The Resistance of the Health Care Industry to ADR*

The fourth axiom is based more on impression than accounting, though deliberate efforts to take the measure have been made more than once. In 1990, this author chaired a team of hospital and insurance attorneys, assembled under the aegis of the then-Center for Public Resources, with the aspiration of assessing the need for ADR in health care, the present state of its utilization, and the adaptations to existing knowledge that would be necessary to make useful what was known from its applications in other fields.[12] A national survey of hospital general counsel, among others, displayed scant use and an equally disappointing lack of interest.[13] In 2003 and 2004, this author, together with Leonard Marcus at the Harvard School of

12. EDWARD A. DAUER ET AL., CPR HEALTH DISPUTES PROJECT, HEALTH INDUSTRY DISPUTE RESOLUTION: STRATEGIES AND TOOLS FOR COST-EFFECTIVE DISPUTE MANAGEMENT 7-9 (1993).

13. *Id.* at 8.

Public Health, attempted to quantify the use of ADR in health care once again—this time by combing the literature and canvassing the network of both ADR providers and health care providers.[14] Again, the data did not allow quantification but it supported the same conclusion—that despite ten years of effort, there has been little progress in the acceptance of ADR by the health care field.[15]

Some anecdotes fill in the picture. The American Arbitration Association ("AAA"), for example, reported that among its many thousands of matters handled, there were few cases having anything whatever to do with health care.[16] They reported that there were only 381 cases in 2000, 377 in 2001, 329 in 2002, and 295 in 2003.[17] Of the 2003 cases, only 15 involved patients, and of those only one involved iatrogenic injury.[18] Most of the remaining cases that year were ordinary commercial matters, as to which health care differs little from other fields (e.g., reimbursement disputes and partnership issues).[19] Moreover, all of the 2003 cases involved arbitrations; there were no mediations in the AAA report.[20] To put this into context, provisions mandating the use of AAA arbitration services have been written into over 6 million health care contracts in California alone, yet there were no cases.[21] Further, the experience of the AAA is not unique. One major health care system, with mediation provisions in over 800,000 contracts, reported but a handful of mediations involving their contracts each year, and only one arbitration.[22]

In 1998 the Physicians Insurance Association of America ("PIAA"), a trade association of physician-owned mutual insurance

14. Edward A. Dauer & Leonard J. Marcus, *Medical Failure and Legal Failure: Applying Alternative Dispute Resolution Methods to Address Health System Problems and Improve Health Care Outcomes* (forthcoming 2005) (on file with the Georgia State University Law Review).

15. *Id.*

16. Dauer & Marcus, *supra* note 14, at 43.

17. *Id.*

18. *Id.* "Iatrogenic injuries are those induced in the patient by action of the physician or other medical personnel." Edward A. Dauer & Leonard J. Marcus, *Adapting Mediation to Link Resolution of Medical Malpractice Disputes with Health Care Quality Improvement*, 60 LAW & CONTEMP. PROBS. 185, 185 n.2 (1997) [hereinafter *Adapting Mediation*].

19. *Id.*

20. *Id.*

21. *Id.*

22. Dauer & Marcus, *supra* note 14, at 43.

carriers, surveyed its member companies, asking for information about their use of mediation in medical malpractice claims.[23] Of the 33 companies responding, 30 reported using mediation but, of those, approximately half mediated fewer than ten cases per year.[24] Since the typical number of new claims each year for those companies is over 600, their mediation rate was less than 2% of all of their cases.[25] More significant, however, was the fact that virtually all of the mediations occurred in cases in which liability was effectively conceded, so that the only remaining issue to be mediated was the amount of damages to be assessed.[26] Moreover, almost all of the mediations occurred late in the conflict resolution process, and an undisclosed portion took place as a result of mandatory, court-ordered programs.[27] The model of mediation employed was predominantly the settlement-conference model—a more or less single-axis, conventional negotiation over the settlement amount.[28]

In addition to few reported malpractice cases, the 2003-2004 industry survey revealed mediations involving end-of-life initiatives that took five years to get into the testing stage; Board of Medical Examiners mediation programs that were tolerated and then, under political pressure, terminated; and more than one system-wide effort vetoed just before implementation.[29]

There are, of course, successes as well. A few mediators are known to have participated in hundreds of private mediations in health care settings. More hospitals than have been described in the literature have various mediation initiatives in place for patient injury claims.[30] A number of individuals, including many of this volume's authors, have been instrumental in working with hospitals and medical groups

23. For a discussion of the survey, see Lori Bartholomew, Remarks at the 39th Annual Conference of the American College of Legal Medicine (Mar. 13, 1999) (PowerPoint slides on file with the Georgia State University Law Review).

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. Dauer & Marcus, *supra* note 14.

30. For a description of many initiatives, see Virginia L. Morrison, *Heyoka: The Shifting Shape of Dispute Resolution in Health Care*, 21 GA. ST. U. L. REV. 931, 956-62 (2005).

to facilitate the resolution of staff and professional problems. Some end-of-life programs are now underway. There are bright spots in the insurance industry such as NORCAL Mutual Insurance Company, COPIC Insurance Company, and a handful of others with enlightened claims resolution policies based in part on ADR principles.[31] Still, a much more typical example is the mediation program created by the Centers for Medicare & Mediation Services ("CMS") to handle complaints taken to the state-operated Quality Improvement Organizations; in two years there were seventeen reported cases.[32] After a decade of trying to encourage the use of ADR methods in the health care industry, it is still good advice to would-be health care mediators that they not give up their day jobs.

### *B. Possible Explanations for the Health Care Industry's Resistance to ADR*

Why is this so? One possibility is that the health care industry does not yet fully understand ADR. There is some reason to believe that this is the case. The results of the PIAA surveys, for example, were entirely consistent with focus group studies conducted by this author and Leonard J. Marcus which indicated that, in the view of the majority of decision makers in health care, mediation is equivalent to settlement or compromise negotiation, a pale reflection of what can actually be accomplished by means of truly integrative mediation. [33] In one other notable anecdote, the Informal Dispute Resolution ("IDR") process adopted by the CMS for dealing with deficiencies in skilled nursing facility inspections is, despite its name, nothing more than an error-checking step on the way to a formal administrative proceeding.[34] The managers of the program have failed or refused to consider the possibility of collaborative learning and improvement as

31. *See* Morrison, *supra* note 30, at 948-56.

32. The latest number, unofficially, is now 90—still a sparse utilization.

33. Edward A. Dauer et al., *Prometheus and the Litigators: A Mediation Odyssey*, 21 J. LEGAL MED. 159 (2000).

34. For a description of the process, see Informal Dispute Resolution, 42 C.F.R. § 488.331 (2004).

a product of the IDR effort.[35] While these illustrations suggest a lack of understanding, it is not likely that the provision of more information about ADR to the health care industry will change things very much. Full-blown efforts to educate health care providers about conflict resolution have yielded disappointing results, although on average, the health care field is populated with more sophisticated professionals than are found in other industries where lesser education efforts have taken hold.

A second possibility is that health care professionals understand ADR completely and do not want to make use of it. Some of the reasons for that resistance may lie in the limitations inherent in the characteristics of ADR discussed earlier.[36] There are many other reasons, however, rooted in the special characteristics and needs of the health care field. For example, proponents of conventional ADR claim "faster, better, cheaper" conflict resolution. These attributes do not serve the interests of health care where patient claims for insurance benefits are involved, however. With multiple levels of contractually-mandated internal appeals, a statutory external review scheme that offers effective protection for later denial-caused injury claims, and ERISA protection for all extra-contractual damages, the health care industry can hardly be faulted for declining to add more layers of procedure in that area.[37] For malpractice claims, the specter of National Practitioner Data Bank reporting and, in many states, public reporting to Boards of Medical Examiners, reduces the

35. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., PUB. 100-7: MEDICARE STATE OPERATIONS MANUAL 7212B (rev. 1 2004), *available at* http://www.cms.hhs.gov/manuals/107_som/som107c07.pdf (explaining that "[t]he purpose of this informal process is to give providers one opportunity to refute cited deficiencies after any survey").

36. *See supra* Part I.A.

37. For a description of typical internal appeal processes, see David M. Studdert & Carole Roan Gresentz, *Enrollee Appeals of Preservice Coverage Denials at Two Health Maintenance Organizations,* 289 JAMA 864, 865 (2003). Many states adopted external review statutes in the period from 1998 to 2003. Managed care entities initially resisted these laws but then embraced them—in part, it may be surmised—to provide some measure of defense against personal injury actions stemming from decisions not to provide requested benefits. The Colorado statute covering independent external review of medical insurance benefit denials is typical of state external review schemes. COLO. REV. STAT. § 10-16-113.5 (2004). For a discussion of the circumstances under which "extracontractual" damages would be available to plaintiffs under ERISA, see Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1334-39 (5th Cir. 1992).

attractiveness of mediation as opposed to vindication of the provider in court.[38] For peer review and quality improvement conflicts, the rules of confidentiality do not fully guarantee against waivers once a neutral outsider steps in.[39] And, to take up a point made earlier, the temporal realities of medical practice most often do not allow for what some physicians regard as time-wasting "kumbayah" sessions with a facilitator. Thus, the hesitance of health care providers about conventional ADR is not necessarily misplaced. As noted before, and to continue the sales analogy, health care is not buying ADR and, absent some change in the product to suit the market, sales are unlikely to improve.

A third possibility is that the health care industry cannot see enough quality in the product to justify buying it. This, too, is entirely rational. The application of ADR in health care settings got off to a bad start.[40] During the 1985-1986 round of state legislative tort reform, special interests parlayed a medical malpractice insurance premium crisis into a nationwide rush toward tort reform. Much of what the reformers sought, such as limits on attorney's fees and other devices that might reduce the absolute incidence of consumer-driven litigation, was not politically possible. At the same time, the ADR community, hitting its philosophical stride, did not have the political muscle to implement its own agenda.[41] The solution for both was obvious—ADR in the form of mandatory diversions from the litigation track was embraced by tort reformers as an alternative way to reduce the incidence of consumer litigation, including medical malpractice. Thus mandatory pre-trial ADR programs, medical

38. Federal law mandates reporting to the National Practitioner Data Bank of any payments, in any amount, made on behalf of a health care practitioner in response to a written medical malpractice claim. Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (2000). In addition to health care providers, many insurers believe the litigation system with its costs and rigors serves their purposes very well; thus, there is no need to change. *See* Dauer et al., *supra* note 33.

39. Also affecting peer review and other quality control measures is the fact that "hospitals, Boards of Medical Examiners, and Medical Societies . . . [must] report any adverse action taken against a physician which affects that person's licensure, membership, or privileges . . . [or any] voluntary suspension of a privilege . . . [and] the penalties imposed for hospitals which do not comply are significant." DAUER ET AL., *supra* note 12, at 14.

40. For a detailed explanation of the reasons for this, see R. MATTHEWS ET AL., HEALTH CARE DISPUTE RESOLUTION: TECHNIQUES FOR AVOIDING LITIGATION 1-24 to 1-28 (2002).

41. *Id.*

screening panels, and other techniques in the ADR armamentarium appeared nearly everywhere.

It did not work. Medical screening panels have been all but abandoned.[42] Mandatory mediation is disfavored in the health care context. Pre-trial arbitration had but a minor impact on eventual malpractice trial rates.[43] The reasons for the failure were plain, at least in retrospect. A "one size fits all" approach to ADR fits nothing. Mandatory procedures conflict with lawyers' needs to manage their cases as they think best. The reformers' goal was not to achieve better resolutions, but only to achieve a reduced incidence of consumer litigation. The failure of this misguided effort gave ADR a bad name, which continues to influence the beliefs of some in the health care industry.

The data provide little to counter concerns about the effectiveness of ADR. Studies of the Civil Justice Reform Act's "pilot districts"—federal district courts which were part of a pilot program designed to test the effectiveness of various case management methods—confirmed by later studies in the state courts, effectively show that court-based ADR programs achieve no results beyond what is expected as a result of improved case management methods in general; whether the improvements are in the form of an ADR program or a more rigorous discovery cutoff does not appear to make a difference.[44] What moves cases and saves money is simply attention to docket management.[45] In the private sector, informal

42. *See generally* Jona Goldschmidt, *Where Have All the Panels Gone: A History of the Arizona Medical Liability Review Panel*, 23 ARIZ. ST. L.J. 1013 (1991) (discussing the reasons for the decline in the use of screening panels and concluding that they do not aid in expediting claims resolution, but hinder the process).

43. The former Congressional Office of Technology Assessment did an extensive study of these and related reforms enacted in the 1970s and 1980s. OFFICE OF TECH. ASSESSMENT, U.S. CONGRESS, PUB. NO. OTA-BP-H-119, IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS (1993), *available at* http://www.wws.princeton.edu/cgi-bin/byteserv.prl/~ota/disk1/1993/9329/9329.PDF.

44. JAMES S. KAKALIK ET AL., JUST, SPEEDY, AND INEXPENSIVE?: AN EVALUATION OF JUDICIAL CASE MANAGEMENT UNDER THE CIVIL JUSTICE REFORM ACT 71-85 (1996), *available at* http://www.rand.org/publications/MR/MR800/800sec5.html#alternative (examining the implementation of ADR as a method of case management in the pilot districts); Roselle L. Wissler, *Court-Connected Mediation in General Civil Cases: What We Know from Empirical Research*, 17 OHIO ST. J. ON DISP. RES. 641 (2002) (examining the effectiveness of state court ADR programs).

45. KAKALIK ET AL., *supra* note 44.

studies have suggested that mediated cases are resolved sooner and involve lower costs than litigated cases. While that is inherently likely on a case-by-case basis—since there is little in ordinary life that costs more than a trial—most of the data cannot be generalized to wider case populations. In virtually all of the reported studies, the cases that went to mediation were selected to go there, as opposed to going to mediation by random assignment. As the PIAA data show, insurers select cases for which they believe facilitated resolution of damage issues will be helpful.[46] There is no reason to believe that mediation is any better than unfacilitated negotiation for those cases, which are typically not destined for trial in any event. It is important to bear in mind that ninety-five percent of all filed cases are settled—many, if not most, without any such facilitation.

One final possibility in this short parade is that health care has been finding at least some of what it needs in terms of conflict resolution elsewhere. The 1990 Center for Public Resources study of ADR utilization in health care revealed that much of the internal dispute resolution occurring in hospitals concerning patient complaints and injuries was being facilitated not under the rubric of ADR, but rather under that of risk management.[47] The meaning of the phrase has changed over time, though a core function has remained: Triggered by incidents rather than claims, risk managers, many of whom are trained as nurses, deal directly with patients in an attempt to resolve difficulties at an early stage.[48] Where there are disputes among practice groups and between physicians and administrators, there is a brisk market in the practice of "meeting facilitation."[49] It is likely that other industry-specific conflict resolution capabilities exist as well, although not yet formally recognized as such in the literature.

There are, in short, ample reasons why ADR may have met daunting challenges in its attempts to be useful to the health care industry. Those discussed here are only among the more obvious. Viewed in light of the characteristics of programs that have worked

46. *See* Bartholomew, *supra* note 23.
47. *See* DAUER ET AL., *supra* note 12, at 28.
48. *Id.*
49. *See, e.g., id.* at 24.

in health care settings, however, they may serve to illuminate where the gap lies.

## III. MODERN APPLICATIONS

A key insight into the peculiarities of health care conflict was gained when two programs, different in some ways and alike in others, were made public. They are both well-known. One is the "3Rs" program of the COPIC Insurance Company in Colorado, a PIAA-member malpractice insurance carrier. [50] The other is the voluntary disclosure program of the Veterans Administration ("VA"), pioneered at its facility in Lexington, Kentucky.[51] In the VA's Lexington model, adverse events are examined for negligent errors.[52] When an error is found, the hospital discloses the facts to the patient, apologizes, describes the follow-up it plans, and makes an up-front offer of compensation.[53] Similarly, the COPIC 3Rs program—in which the three Rs stands for "recognize," "respond," and "resolve"—is instigated by the recognition of an incident, prior to the time any claim is made.[54] Like that of the VA, the effort includes direct communication between the patient and the doctor, facilitated in COPIC's case by an agent of the insurance company who has authority to grant compensation on the spot.[55] Apology plays a role in both programs, as well as an explanation of the event and of the steps taken to correct the cause of the error.[56] Both programs report favorable financial results, both report improved doctor-patient

50. For a description of the program and a summary of its first three years' results, see *A Success Story,* COPIC'S 3RS PROGRAM (COPIC Ins. Co., Denver, Colo.), Mar. 2004, at 1, *available at* www.callcopic.com/publications/3rs/march_2004.pdf [hereinafter *A Success Story*].

51. For a description of the program and its results, see Steve S. Kraman & Ginny Hamm, *Risk Management: Extreme Honesty May Be the Best Policy*, 131 ANNALS INTERNAL MED. 963 (1999).

52. *Id.* at 964.

53. *Id.*

54. *A Success Story*, *supra* note 56.

55. *See id.*

56. Kraman & Hamm, *supra* note 57; *see A Success Story*, *supra* note 56.

relations, and the COPIC program reports enthusiastic reviews by both patients and providers.[57]

What is most interesting about these programs and other, less well-known programs like them, is in clear contrast to the conventional characteristics of ADR: There is no independent neutral, and the conflict is addressed before it becomes a lawsuit or even a dispute. These programs build on, and in return validate, what has been known for some time about the origin of medical malpractice claims—namely, that the impetus for suit lies more often in the emotional consequences of what the medical facility personnel do in the aftermath of an error than it does in the degree of legal risk or, to a lesser extent, in the degree of physical injury.[58] At risk of overstating it, programs that respond to those kinds of concerns—concerns rooted in fear, in disappointment, in the sense of having been abandoned—treat legal disputes as the epiphenomena that they are. The real problem in need of management is the underlying potential for conflict, not the dispute itself. Conventional applications of ADR, in other words, treat symptoms, but not the problem.

## IV. SHIFTING FOCUS: THE ROLE OF CULTURE

Thus far, this is the background against which this Symposium was assembled. What is most striking in the Symposium articles themselves is the central importance the authors assigned to the role of culture. Although each author has at least implicitly some assumption about what that word means, most declined to define it,

57. Kraman & Hamm, *supra* note 57; *Feedback*, COPIC'S 3RS PROGRAM (COPIC Ins. Co., Denver, Colo.), Oct. 2004, at 1, *available at* http://www.callcopic.com/publications/3rs/vol_1_issue_2_oct_2004.pdf [hereinafter *Feedback*]. COPIC surveys physicians and patients following the resolution of each 3R case. *Id.* COPIC has also recently conducted focus groups among patients served by the 3Rs program. The study has not yet been published. Personal communication with the General Counsel of COPIC (Nov. 2004) (regarding as-yet-unpublished studies of satisfaction measures among physicians and patients).

58. The literature is abundant. *See, e.g.*, Thomas H. Gallagher et al., *Patients' and Physicians' Attitudes Regarding the Disclosure of Medical Errors*, 289 JAMA 1001 (2003); Charles Vincent et al., *Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action*, 343 LANCET 1609 (1994); Kathleen M. Mazor et al., *Health Plan Members' Views About Disclosure of Medical Errors*, 140 ANNALS INTERNAL MED. 409 (2004).

and for good reason: The definition of culture is a work in process that has defied closure among anthropologists for more than a century.[59] The authors might agree, however, that it is at least this: a collection of values, meanings and behaviors, and expectations about values, meanings, and behaviors, which are shared among the members of a definable group. As Debra Gerardi suggested, the culture of an organization is the nonverbal part of the ongoing conversation among the individuals who comprise the organization.[60] Given that much, the authors would likely agree that health care and the subcultures within health care are unique.

Taken together, the message the Symposium authors offer is twofold. First, culture matters, and ADR offered without sensitivity to that fact will either fail or be rejected. Second, the contribution ADR may make to health care includes its transformative potential—nothing less than helping change the culture of health care itself.

### *A. The Significance of Health Care Culture and Subcultures*

On the first point—that culture matters in the design and acceptability of ADR—considering the importance of culture is, in itself, not new. The dispute resolution literature abounds with discussions of cross-cultural negotiation, both international and inter-ethnic (even, if one might call these differing cultures, inter-gender). The role of culture as described in this volume, however, goes further and deeper than the obvious admonition that a mediator or other ADR neutral, to be successful, must understand the cultural background of the parties in the dispute before them. As Coby Anderson and Linda D'Antonio pointed out, culture is what defines something as a *dispute* in the first place.[61] Gerardi agreed, citing one study in which 73% of the physicians in a unit reported that the level

59. *See, e.g.*, *Definitions & Discussions of Culture: John H. Bodley, An Anthropological Perspecitve*, Washington State University, *at* http://www.wsu.edu:8001/vcwsu/commons/topics/culture/culture-definitions/bodley-text.html (last visited Apr. 13, 2005) (attempting to define culture and citing JOHN H. BODLEY, CULTURAL ANTHROPOLOGY: TRIBES, STATES, AND THE GLOBAL SYSTEM (1994)).

60. Gerardi, *supra* note 9, at 867.

61. Coby J. Anderson & Linda L. D'Antonio, *A Participatory Approach to Understanding Conflict in Healthcare*, 21 GA. ST. U. L. REV. 817, 817 (2005).

of doctor-nurse collaboration was high, while only 33% of the nurses in that same unit thought so.[62] Within the physicians' subculture, collaboration means seamless implementation of their decisions. For the nurse, collaboration means appreciation for their unique contribution to the patient's care. A dysfunctional and acerbic two-way communication might be a conflict for a nurse, but may not be for a physician. Similarly, a culture that supports the value of being a loner is less likely to define failures in cooperation as conflicts. Subgroups that value relationships because they view their work as collective will see conflict, where subgroups that value the work of individuals will see none. Where a conflict can pass without consequence, there may be no recognition of a conflict. Linda Morton's extraordinary educational foray into "problem solving" in health care recognized this potential—her students were not allowed to bring their own frame of reference to their clients; instead, they were instructed to identify real problems by adopting the values and concerns of the problem-owner.[63]

The clarion call on this point was an earlier study by Anderson and D'Antonio, rehearsed and advanced in the present work.[64] In contrast to the many who would bring ADR methods to what they regard as health care's dispute inventory, Anderson and D'Antonio took the bold step of asking people inside health care what they thought their problems were.[65] Comparing the responses of health care professionals with the projections of ADR providers was illuminating, to say the least. Conflicts with patients, which ADR practitioners would have ranked first, was low on the health care providers' list.[66] Anderson and D'Antonio found that fully half of health care professionals' time was suffused with conflict, and that the vast majority of it was conflict among physicians or between

62. Gerardi, *supra* note 9, at 874.

63. Linda Morton, *A New Approach to Health Care ADR: Training Law Students to Be Problem Solvers in the Health Care Context*, 21 GA. ST. U. L. REV. 965 (2005).

64. Coby Anderson & Linda L. D'Antonio, *Empirical Insights: Understanding the Unique Culture of Health Care Conflict*, DISP. RESOL. MAG., Fall 2004, at 15.

65. *Id.*

66. *Id.* at 16.

physicians and hospital administrators.[67] Many ADR professionals, and certainly many lawyer ADR professionals, might not even regard these daily interactions as conflicts.[68] No one involved makes a claim of right and, most often, there is not even a sufficient interruption in the routine for the occasion to be a discretely recognizable event. But within the culture of health care, these are the dominant conflicts.

Culture matters in a second way: It constrains the shape of process and the attractiveness of outcomes. Marc Lebed, a physician himself, described a cultural norm among physicians that resists delegating responsibility.[69] Physicians feel expected to solve their own problems, not to hand them off to outsiders—a sense that leads them to believe, "If I can't fix it, it can't be fixed."[70] Application of ADR methods utilizing third-party neutrals challenges this norm. The "shuttle" mediation that Dale Hetzler considered most frequent among malpractice neutrals—settlement-focused rather than resolution-focused—is also counterproductive, when the interests of the health care participants include rebuilding trust among patients, physicians, and hospitals.[71]

Much of the conflict within health care arises from clashes among its many subcultures, and from the differences between internal cultures (e.g., doctors, whose goal is objective health) and external cultures (e.g., patients, whose interests may be more subjective, such as receiving caring treatment during their condition of dependency).[72] Any ADR process that does not include an appreciation for these origins is likely to leave underlying problems unaddressed, or to resolve the superficial problem but leave the people unsatisfied. At the most mechanical level, typical mediation styles may be

67. *Id.*

68. *See id.*

69. Marc R. Lebed & John McCauley, *Mediation Within the Health Care Industry: Hurdles and Opportunities*, 21 GA. ST. U. L. REV. 911 (2005).

70. *Id.*

71. Dale C. Hetzler, *Superordinate Claims Management: Resolution Focus from Day One*, 21 GA. ST. U. L. REV. 89, 902 (2005).

72. *See* Gerardi, *supra* note 9, at 859. Anderson and D'Antonio saw a similar cultural divide between physicians, whose education leads them to value inductive reasoning, and lawyers (as ADR professionals), whose education steers them to value the deductive. Anderson & D'Antonio, *supra* note 67.

insensitive to the real-time in which health care conflict occurs and the short timeframe available in which to address it. Although power-based procedures such as arbitration may, as Ellwood Oakley pointed out, still have a proper role in addressing matured conflicts voiced in claims of legal right, these procedures may be incompatible with the sense of responsibility and authority of health care providers.[73] Even with respect to facilitative procedures (such as mediation), physicians—who believe their craft rests on complex insider knowledge—distrust non-physician mediators, not only for their lack of substantive knowledge but also because the culture of physicians has lately become suffused with the fear of a loss of professional autonomy.[74] Insiders are those who share a culture. Outsiders are outsiders.

In a more subtle but equally powerful way, the cultural premises of ADR itself can get in the way. Mediators are trained to avoid win-lose contests, seeking instead win-win solutions. In practice, the message often becomes that one party does not have to be wrong in order for the other party to be right. In other words, mediators optimistically convey the message that it is not necessary to conclude the provider was incompetent in order to meet the patient's need for recognition and response. But where the culture requires that there be some individual to blame for every error, integrative approaches will be a hard sell at best.[75] Gerardi echoed here the work of Lucian Leape and others who have criticized the culture of physicians as one that suborns individual responsibility, translating errors into personal fault.[76] Physicians are conditioned to see resolution as a form of compromise, and compromise as concession of personal failure.[77]

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73. Ellwood F. Oakley, III, *The Next Generation of Medical Malpractice Dispute Resolution: Alternatives to Litigation*, 21 GA. ST. U. L. REV. 993, 998-99 (2005).

74. Lebed & McCauley, *supra* note 75, at 918.

75. Gerardi, *supra* note 9, at 871.

76. *Id.*; Lucian Leape, *Error in Medicine*, 272 JAMA 1851 (1994). *Error in Medicine* is among Leape's best known works on this topic.

77. This process is aided by the law, including the Health Care Quality Improvement Act of 1986 and the Act's requirements for reporting compensation paid to malpractice claimants to the National Practitioner Data Bank. *See supra* notes 41-42 and accompanying text.

Many years ago, Leonard Riskin praised ADR as an antidote to "the lawyers' standard philosophical map."[78] In Riskin's view, litigators impose the taxonomy of the law on peoples' problems and insist on solving them in the only ways allowed by that classification.[79] ADR, Riskin believed, avoids that error by avoiding the legal preconception.[80] Perhaps ADR proponents, in their initial efforts to come to the aid of health care, have been guilty of the same error for which Riskin criticized the litigators—the error of imposing ADR's conceptual map on the very different cultural map of health care. Morton's prescription, though she may not have put it this way, is to suspend the problem-solving agent's map entirely in favor of that of the problem-holder.[81] Gerardi suggested the development of additional tools: transformational interviewing, narrative inquiry, cultural inventory, and others that blend the insights of organizational theory with those of traditional ADR.[82]

In the articles in this volume, culture is assigned one additional role: It is a source of resistance to change.[83] Culture, after all, serves as a font of stability within societies and possibly within organizations and professions as well. Stability is part of its worth.[84] Resistance to change—such as lack of the acceptance of ADR—is a natural consequence of stability.[85]

### *B. Changing the Culture of Health Care*

The second theme apparent among the articles in this Symposium volume is that what ADR has to offer health care is a vehicle for change within health care's culture. This may be attributed to an appreciation for the consequences of conflict. As Gerardi noted, "The ADR community has much to offer and an important role to play in

78. Leonard L. Riskin, *Mediation and Lawyers*, 43 OHIO ST. L.J. 29, 43, 57-58 (1982).
79. *Id.* at 44-45.
80. *Id.* at 44.
81. *See supra* note 69 and accompanying text.
82. Gerardi, *supra* note 9, at 889.
83. *See, e.g.*, Gerardi, *supra* note 9, at 859; Lebed & McCauley, *supra* note 75, at 816.
84. *See* Gerardi, *supra* note 9, at 858-59.
85. *See id.*

the creation of safer healing environments."[86] Why is this so? To some extent, the answer is obvious. As health care itself becomes more complex and as knowledge becomes deeper, the trend to specialization is inevitable; yet from the perspective of patient care, despite all the individualism in providers' cultures, providing health care is a team effort. Collaboration is essential. Whatever inhibits collaboration inhibits the quality of care.[87] Although the adverse implications of unresolved conflict have been noted elsewhere, the articles in this volume add two significant new dimensions: a major refocus on the importance of patient safety, and new information demonstrating that the link between potential conflict and patient safety is real.

Since at least 1999, which marked the release of the Institute of Medicine's report, *To Err is Human*, national attention has been directed to the incidence of iatrogenic injury and to the "systems" approach for addressing it.[88] In an interesting way, the bane of the malpractice system—the malpractice insurance premium pricing cycle—has given patient safety a soapbox it might not otherwise have had. While tort reformers have cited the impact of legal excesses on malpractice insurance premiums as the basis for substantive legal change, others in the health care community have responded by pointing to the unmet challenge of reducing the incidence of error to enhance patient safety. The tort reformers have brought the spotlight to their adversaries as well as to themselves; patient safety is all the rage.

The shibboleth of patient safety—that "every error is a treasure"—teaches that every unexpected adverse event is a window through which it may be possible to see the cause.[89] Root Cause Analysis has

86. Gerardi, *supra* note 9, at 890.

87. Morrison, *supra* note 30, at 933-34; *see also* Ansley Boyd Barton, *Recent Remedies for Health Care Ills*, GA. ST. U. L. REV. 831, 854 (2005); Gerardi, *supra* note 9, at 874; *Adapting Mediation*, *supra* note 20, at 186.

88. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Cohn et al. eds., Nat'l Acads. Press 2000)

89. This concept generally comes from the philosophy of "Kaizen" from Japanese industry, which teaches that "every defect is a treasure that can point the way to improvement." Fiona Moss et al., *Quality Improvement Around the World: How Much We Can Learn from Each Other*, 9 QUALITY HEALTH CARE 63, 65 (2000), *available at* http://qhc.bmjjournals.com/cgi/reprint/9/1/63.pdf.

been described as a "backward march of whys," starting with the outcome and searching for the process upsets or system attributes that both caused it and allowed it to happen.[90] Achieving this goal requires collecting reported data about adverse events, engaging the voluntary cooperation of those who can contribute to its analysis, and a forthright recognition that errors are sometimes the outputs of decent, albeit improvable, systems.[91]

In the real world of health care, the culture is usually nothing like that. The specter of potential malpractice litigation, with its amplifiers in the National Practitioners Data Bank and related state programs, positively inhibits the collection of data, the spirit of cooperation, and the recognition of errors as reality.[92] The same can be said for the prospect of peer review, de-credentialing, or action by a state licensing board.[93] Providers have a disincentive to report the facts of an adverse event, if doing so would simply instigate or support a legal claim by a patient-turned-plaintiff, or cause other legal risk to the provider. Ansley Barton's contribution to this volume is a grand accounting of state and federal legislation spurred in large part in response to this premise and the new focus on health care culture.[94] State-sponsored data reporting centers, for example, recognize that an error may simply be an error, rather than just the occasion for a dispute.[95]

Building on data originally developed by Hickson, and confirmed by many others since, some health care institutions have shown the courage to behave in a different way, shifting their internal cultures and reducing the disincentives to voluntary disclosure of errors.[96] Hetzler reported that Children's Healthcare of Atlanta insists on

90. *See* Rebecca Voelker, *"Treat Systems, Not Errors," Experts Say*, 276 JAMA 1537, 1538 (1996) (quoting Dennis O'Leary, M.D., President of the Joint Commission for the Accreditation of Health Care Organizations and relaying his description of the organization's "sentinel event" process).

91. *See id.*

92. *See supra* note 41-42 and accompanying text.

93. *See id.*

94. Barton, *supra* note 93.

95. *See generally id.* (describing various state programs which provide methods of confidential medical error reporting).

96. Gerald B. Hickson et al., *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359 (1992); *see also* Gallagher et al., *supra*, note 64.

treating potential plaintiffs as the patients they are and, it is hoped, they will still be in the future.[97] The legal plank of the medical culture is thus transformed by the process to more accurately reflect the medical component of the medical culture—namely healing, nurturing, and respect. Turning from defending claims to rebuilding trust also turns out to be a good way to defend claims. That aspect of the new shift in the focus on the health care culture is truly striking. The now-famous Lexington model, for example, showed that voluntary disclosure and appropriate compensation, combined with explanation and appropriate apology, not only results in savings from deflected claims that are demonstrable in hard dollars, but also factors the patient back into the equation in the search for quality improvement.[98] The COPIC experience adds that its program maintains the therapeutic potential of the doctor-patient relationship.[99] What ADR can provide to this cultural revolution is impetus and experience. Collaboration, candor, and effective communication are the central stock in trade for ADR practitioners.

Ginny Morrison's article does for the practice of conflict resolution what Barton's article does for changes in the law.[100] With her extraordinary grasp of the state of the art, Morrison outlined three avenues of progress in addition to the conventional, illustrating how the focus of ADR itself has begun to shift from its less-successful history of impressing itself on an alien culture, to its more promising present state of helping "to shift [health care's own] culture in favor of interest-based thinking and collaborative practices."[101]

The first of the three avenues is education.[102] Some medical schools and some residencies now include training in the collaborative arts and in communication skills.[103] To counteract the

97. Hetzler, *supra* note 77, at 898.

98. *See* Kraman & Hamm, *supra* note 57, at 966.

99. *See, e.g.*, *Feedback*, *supra* note 63 (reporting that their 3Rs program has resulted in "enhanced physician/patient communication, sustained physician/patient relationship, and improved satisfaction on the part of all concerned parties").

100. Morrison, *supra* note 30.

101. *Id.* at 933.

102. *Id.*

103. *Id.* at 934-36.

silo thinking of subcultures, some programs engage their students in interdisciplinary programs while they are still impressionable, before ineffective methods of communicating and interacting are handed down to them from experienced doctors.[104]

A second avenue is that of building ADR techniques into existing practice mandates (e.g., a bioethics committee that uses mediation to address end-of-life conflicts).[105] Accreditation requirements have also incorporated some of these techniques.[106] Root Cause Analysis and Failure Mode Analysis, themselves now demanded, in turn demand collaborative investigation.[107] New laws in many states now mandate disclosure of errors to patients, making that form of communication a part of ordinary medical life.[108] All of these changes are changing the culture of health care, and all of them call on the skills and sensitivities for which ADR is well and correctly known.

Morrison's third avenue involves bringing ADR indoors.[109] Rather than calling on outside ADR providers episodically when a conflict matures into a dispute, some hospitals and health plans are creating internal facilitation capabilities, making them integral parts of the institution, and offering coaching and education as well as hands-on service.[110] All of this is done, Morrison reported, in advance of disputes to "[lay] the foundation for a culture emphasizing early and direct conflict resolution," reflecting the shift in focus from dispute resolution to conflict management.[111] The advantage is obvious—internalizing these functions makes them part of the culture, rather than an intrusion into the culture. Coby Anderson and Linda D'Antonio reported a like success: The hospital-based providers they

104. *Id.* at 936-38.

105. *Id.* at 941.

106. Morrison, *supra* note 30, at 946-47.

107. *Id.* at 943. Hospitals accredited by the Joint Commission on Accreditation of Healthcare Oragnizations ("JCAHO") must conduct Root Cause Analyses following specified adverse events. For a description of the requirements, see *Sentinel Event Policy and Procedures*, Joint Commission on Accreditation of Healthcare Organizations, *at* http://www.jcaho.org/accredited+organizations/sentinel+event/se_pp.htm (updated Mar. 2005).

108. *See, e.g.*, Morrison, *supra* note 30, at 946. Examples include FLA. STAT. ANN. § 395.1051 (West 2005); N.J. STAT. ANN. § 26:2H-12.25 (West 2004); PA. STAT. ANN. tit. 40 § 1303.308 (West 2005).

109. Morrison, *supra* note 30, at 956.

110. *Id.* at 957-58.

111. *Id.* at 957.

surveyed jumped at the chance to be trained in how to deal with their own conflicts themselves.[112] It might safely be guessed that the same people otherwise would have joined the multitudes of those in health care who have rejected the advances of traditional ADR. This is the lesson that ADR in search of a role in health care has had to learn.

Finally, Jennifer Robbennolt served a reminder that there is still a great deal to be learned.[113] An integral part of the brave new world of openness and disclosure is the role of apology, taken more broadly as communication in the aftermath of accident or error.[114] Robbennolt might disclaim the honor, but it is true nonetheless that her empirical work, like Cohen's theoretical and legal analyses, has brought an extraordinary depth and rigor to what we know about the interactions of communication and conflict.[115] In truth as well as professional modesty, she catalogues with special attention to health care what we know, and what remains to be known. Still—and all in all—what a great new beginning.

## CONCLUSION

For all the reasons described above, ADR in health care got off to a shaky start. This time, it appears that the initial response has been much better. ADR professionals have apparently learned a great deal, and the evolution of dispute resolution into conflict management has been a much needed advance. It is probably still too early for those who want to sell ADR to the health care industry to quit their day jobs, but the efforts of the participants in this Symposium have brought that time closer.

112. Anderson & D'Antonio, *supra* note 67, at 822.

113. Jennifer K. Robbennolt, *What We Know and Don't Know About the Role of Apologies in Resolving Health Care Disputes*, 21 GA. ST. U. L. REV. 1009 (2005).

114. *Id.* at 1009-11.

115. *See* Jennifer K. Robbennolt, *Apologies and Legal Settlement: An Empirical Examination*, 102 MICH. L. REV. 460 (2003); Jonathan R. Cohen, *Advising Clients to Apologize*, 72 S. CAL. L. REV. 1009 (1999); Jonathan R. Cohen, *Apology and Organizations: Exploring an Example from Medical Practice*, 27 FORDHAM URB. L.J. 1447 (2000).